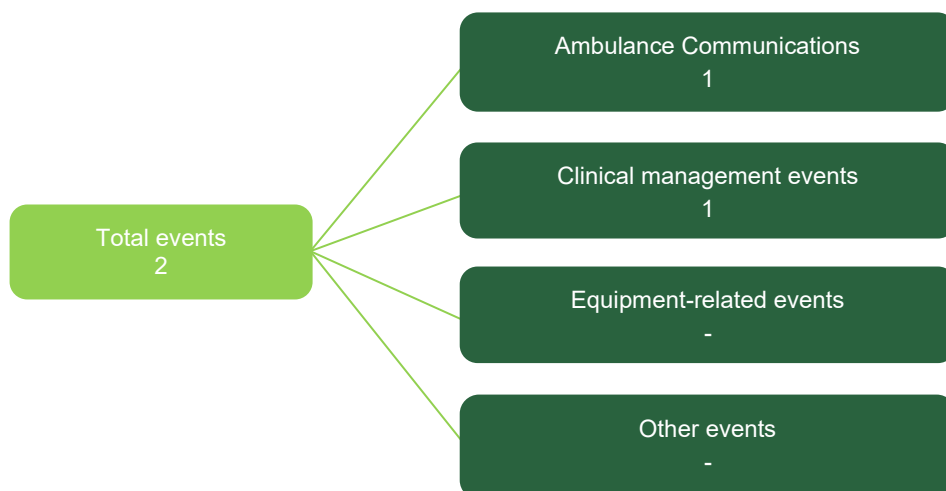




Emergency Ambulance Service Reportable Events: Jan-Mar 2026

Total number of reportable events and near misses

- Two closed SAC 2 reportable events were reported to NAT for the period.
- 11 SAC 2 reportable events remained open as at the end of the quarter.



Ambulance Communications

#	Summary of Reportable Event	Root Cause Analysis	Recommendations	Action Taken
REP35401	Delayed response of ambulance to high acuity patient.	In two instances during the welfare checks, the caller was not asked "has there been a change in the patient's condition?" resulting in missed opportunities to identify any deterioration in the patient's condition. The incident was not managed accordant with standard dispatch processes.	<p>Undertake a review of the secondary triage approach to clinical safeguarding long liers.</p> <p>The call-handler undergo a debrief with the Primary Triage Manage and education be provided outlining the importance of adhering to CCSOP 1.20 (Welfare Checks).</p> <p>The dispatchers to undergo a debrief with the Dispatch Manager and clinical support be provided by outlining the importance of adhering to DPSP 3.21 (Dispatch Guidelines).</p>	<p>Review completed, and a large number of protocol 17 (falls) determinants have been selected for the CSO NAV queue for the performance of secondary triage to ensure the appropriate response priority is selected.</p> <p>Provision of additional information to CSOs through Manchester Triage System, including guidance on how a CSO can instruct a patient to get themselves up from the floor, information for bystanders and referral pathways for patients that may undergo 'hear and advise.'</p>

				<p>The Welfare Check SOP 1.20 has undergone review and is being progressed for final approval.</p> <p>Debrief and education provided to call-handler.</p> <p>Debrief and structured support provided to dispatcher.</p>
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Clinical Management Events

#	Summary of Reportable Event	Root Cause Analysis	Recommendations	Action Taken
REP35428	Initial non-transport of patient that was re-attended within 24 hours.	The incident was downgraded as while the initial review highlighted concerns regarding the decision not to transport the patient to hospital, it was reasonable to leave an uninjured patient at home who was competent and refused further assessments and interventions. While the patient refused assessment, no refusal for treatment or assessments was documented.	The ambulance personnel undergo a Deputy Clinical Director led debrief of the incident to encourage learning and reflection on the incident.	Debrief and structured support enacted.